DIVISION OF MATERNAL AND CHILD HEALTH

Authorization for Services

1. **Vendor Name**: _____

2. **Vendor Address**: _____ **Vendor Tax ID #**:_____

_____ **Phone Number:** _____

3. **Name of Patient**: _____ 4. **Birth Date**: _____

5. **Patient's Address**: _____ 6. **County of Residence**: _____

_____ 7. **Clinic Location**: _____

8. Name of Parents or Guardian, if applicable: _____

9. Diagnosis: _____

10. Type of Service (check one): Physician Services ☐ Other (specify) ☐ _____
Metabolic formula ☐ Metabolic food products ☐

11a. Specify Services Requested: Itemized Charges:

_____ _____

_____ _____

_____ _____

11b. Invoice #_____ 12. **TOTAL** $_____

13. _____ 14._____
P.O.E./Agency Personnel Requesting Service(s) — Date of Service(s)

15. _____ 16._____
Patient or Responsible Party Receiving Service(s) (Signature) — Date Received

17. _____ 18._____
Vendor (Signature) / Providing Service(s) — Date of Service(s)

STATE AGENCY USE ONLY
Expenditures Authorized

Amount $_____ Date: _____

Authorized By: _____

Please submit **ORIGINAL** to: Division of Maternal and Child Health
275 East Main Street, HS2W-C
Frankfort, Kentucky 40621-0001

Attention: KY Metabolic Foods & Formula Program
Phone: 502-564-3756 x4367
Fax: (502) 564-1510